



Medicare  
Payment Advisory  
Commission

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**MEDICARE PAYMENT ADVISORY COMMISSION  
RELEASES REPORT ON MEDICARE PAYMENT POLICY**

**Washington, DC, June 15, 2005** — Today, the Medicare Payment Advisory Commission (MedPAC) releases its June 2005 *Report to the Congress: Issues in a modernized Medicare program*.

In this report, MedPAC addresses some of the key issues in the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA); looks at how the Medicare program can pay more accurately for services and maintain neutrality across settings; and reports on three issues that the Congress mandated in the MMA.

The MMA introduced a voluntary Medicare prescription drug benefit, which begins in 2006. The report reviews measures that CMS could use to evaluate plan performance and monitor Part D. It calls for the Secretary to develop a plan for the timely delivery of Part D data to Congressional support agencies so that they can better inform the Congress about the drug benefit's impact on cost, quality, and access. The report also looks at techniques developed in the commercial market to help manage utilization and to ensure members access to needed drugs, and considers experience in enrollment issues gained from the Medicare discount drug card program.

The Commission strongly supports giving Medicare beneficiaries a choice to join private plans, because these plans have greater flexibility to improve the efficiency and quality of beneficiaries' health care services. However, the Commission has a long-standing principle that there should be financial neutrality between private plans and fee-for-service (FFS) Medicare to encourage efficiency and promote the entry of plans that will remain in markets long term. The report makes several recommendations to maintain neutrality between private plans and FFS Medicare, as well as among private plans. These include:

- collecting quality measures for the FFS program that would enable comparison with the Medicare advantage (MA) program;
- eliminating the preferred provider organization stabilization fund;
- clarifying that regional plans should submit bids that are standardized for the region's MA-eligible population;
- putting in law the scheduled phase-out of the hold-harmless policy for risk adjustment;
- removing the effect of payments for indirect medical education from the MA plan benchmarks; and
- linking payment benchmarks for MA plans to 100 percent of FFS costs, while returning savings from bidding to plans by rewarding quality performance. The benchmark might be set to 100 percent of FFS in the aggregate, rather than in each payment area.

Because the bidding process is underway, a sharp change in payments could be disruptive and implementation of the recommendations would take this into account.

The MMA improved payment for dialysis services in some ways, but Medicare still pays dialysis providers differently based on site of care and type of drug. The report recommends improvements to the payment system, including that Medicare pay the same amount at hospital-based and freestanding dialysis facilities. In addition, Medicare should use the same payment method—average sales price—to pay for all dialysis drugs provided by both facility types. MedPAC also calls for the HHS-OIG to collect acquisition cost data from dialysis facilities to compare with average sales price data.

The report finds that a different patient assessment tool is used in each post-acute care setting, which makes it difficult to compare patients and outcomes among settings. This raises concerns that payments may not be balanced across settings and that patients may not go to the best setting for their condition. The report also finds costs and outcomes differ by setting for hip and knee replacement patients, but that finding is difficult to evaluate without a common assessment tool. Finally, the report reviews a series of issues related to reforming the skilled nursing and home health prospective payment systems.

The MMA directed MedPAC to study three issues: (1) MA program payment areas and risk adjustment, (2) pharmacy and nuclear medicine handling costs, and (3) critical access hospitals. The report finds that:

- The Congress should establish larger payment areas for MA local plans to stabilize rates and approximate private sector market areas, and that the CMS-hierarchical condition category risk adjustment model performs better than the model used in the past.
- Pharmacy and nuclear medicine handling costs warrant a separate (budget-neutral) payment. Additionally, in general, larger payment bundles would create stronger incentives for efficiency in the outpatient PPS.
- The CAH program has succeeded in protecting the financial viability of many small rural hospitals; closures of CAHs have almost ceased. As a result of the CAH provisions in the MMA, a few more hospitals will convert this year, but conversions will effectively end after 2005 when about 1,300 hospitals will be in the program. Cost-based payments for CAHs will total about \$5 billion in 2006—roughly \$1.3 billion more than PPS payments would have been. Payment modifications and other adjustments may need to be made to ensure fair competition, because some CAHs are located quite close to other providers that do not receive cost-based payment.

The report also notes that cost-effectiveness analysis has the potential to promote care that is more cost efficient and higher quality, if the valid concerns about its methods are addressed. Medicare could play an important role in standardizing the methods in these analyses. Finally, as mandated by the Congress, the report discusses the HHS Secretary's estimate of the payment update for physician services and notes that CMS's preliminary estimate of growth in physician fee schedule expenditure in 2004 is 15.2 percent.

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*The Medicare Payment Advisory Commission is an independent Congressional advisory body charged with providing policy analysis and advice concerning the Medicare program and other aspects of the health care system. Its 17 commissioners represent diverse points of view and include health care providers; payers; beneficiary representatives; employers; and individuals with expertise in biomedical, health services, and health economics research.*